City of St. Louis Police Division

Enrollment Application and Change Form

Anthem

☐ New Coverage ☐ Request for Change ☐ End Coverage Due to a Qualifying Event

1 MEMBER INFORMATION

Last Name	First Name	MI	Sex	Date of Birth	Social Security Number	Marital Status
			☐ Male ☐ Female			☐ Single ☐ Married ☐ Domestic Partner

Home Address	City	State	Zip Code	Home Phone Number
				( )

Employer Name	Department	Email Address		Work Phone Number
City of St. Louis Police Division			☐ Active ☐ Retired (Date _____)	( )

2 TYPE OF MEDICAL COVERAGE

☐ **Base Plan**
☐ **Buy-Up Plan**
☐ **High Deductible Health Plan**
☐ I decline coverage for myself
☐ I decline coverage for my dependents
Reason: ☐ covered under another plan
☐ Other: _____
(see sections 6&7)

***Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee and you will have to wait to enroll during the next open enrollment period.**

3 WHO SHOULD BE COVERED

☐ Member Only
☐ Member Plus Spouse
☐ Member Plus Child(ren)
☐ Member Plus Family

TYPE OF CHANGE

☐ Add Spouse/Child (complete Sec.5)
☐ Terminate Spouse/Child (complete Sec. 5)
☐ Address (enter above)
☐ Name Change (complete Sec.5)
☐ Reinstatement – Reason

☐ **Surviving Spouse – Former Member SSN** _____
☐ **COBRA Continuee – Former Member SSN**
☐ Other _____

HIPAA Qualifying Event Date of qualifying event: ____/____/_____.
☐ Marriage, ☐ Birth, ☐ Adoption, ☐ Legal Guardianship, Other _____

5 COVERAGE INFORMATION

(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Dependent SSN	Date of Birth (MM/DD/YY)	Sex	Other Insurance	Disabled
	Member							
	Spouse					☐ M ☐ F	☐ Y ☐ N	
	Child 1					☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N
	Child 2					☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N
	Child 3					☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N

6 OTHER INSURANCE

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another Anthem plan, Medicare or Medicaid?. . . . . ☐ Y ☐ N

Is another person legally responsible for coverage for your children? . . . . . ☐ Y ☐ N

If you answered yes to either of the questions above, please complete the following:

Person's Name with Other Health Plan		Social Security Number
Date of Birth	Sex	Other Company's Name and Phone Number
Other Company's Policy Number and Effective Date		
Medicare Number	Part A Effective Date	Part B Effective Date

7 AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give Anthem Blue Cross and Blue Shield and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct. If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay.

NOTICE OF ENROLLMENT RIGHTS

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, I and/or my dependents will have to wait until the next open enrollment period, unless I and/or my dependents have a qualifying event. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after such marriage, birth, adoption, or placement for adoption.

Health Insurance or medical services benefits provided or administered by Healthy Alliance Life Insurance Company d/b/a Anthem Blue Cross and Blue Shield.

X Signature _____ Date _____

8 TO BE COMPLETED BY EMPLOYER

Date of Hire	Date Submitted	Health/Change Eff. Date	Health Plan	SUBGROUP	Employer Signature
			Blue Access Choice (STL Area)		

Choosing Your Medical Plan

Base Plan – Highest premium with lowest out-of-pocket costs. REFERRALS ARE NO LONGER NEEDED.

- You will pay a co-pay for most in-network services. Primary Care Physician - $25; Specialist - $50; ER - $500; Urgent Care - $50; LiveHealth Online - $25.
- In-network deductible is $800 single / $2,400 family.
- In-network out-of-pocket maximum is $5,350 single / $10,700 family.

Buy-Up Plan – Less premium than High Plan, but higher out-of-pocket costs. REFERRALS ARE NO LONGER NEEDED.

- You will pay a co-pay for most in-netowork services. Primary Care Physician - $15; Specialist - $35; ER - $500; Urgent Care - $50; LiveHealth Online - $15.
- In-network deductible is $300 single / $900 family.
- In-network out-of-pocket maximum is $2,000 single / $6,000 family.

High Deductible Health Plan – Lowest premium with highest out-of-pocket costs. REFERRALS ARE NO LONGER NEEDED.

1. You pay for all expenses until you reach your deductible. In-network deductible is $3,000 single / $6,000 family. In-network out-of-pocket maximum is $4,000 single / $6,850 family.
   - You are responsible for all eligible expenses, such as a doctor visit or a prescription. The amount you pay will apply to your deductible.
   - You will pay the full cost of your health care expenses until you meet your deductible, with the exception of Preventative Care which is covered at 100% with no deductible.

2. If you cover anyone other than yourself, you pay the family deductible before the plan pays and out-of-pocket maximum applies.
   - For example, if you have EE+SP or EE+CH coverage, you will be responsible for paying $6,000 before the plan pays 90%.

3. Once the deductible is paid, the plan will pay 90% of each medical service and you will pay 10%.